Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 23, 2014	2014_219211_0019	T-114-14	Resident Quality Inspection

Licensee/Titulaire de permis

WEST PARK HEALTHCARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

Long-Term Care Home/Foyer de soins de longue durée

WEST PARK LONG TERM CARE CENTRE
82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

JOELLE TAILLEFER (211), LAURA BROWN-HUESKEN (503), SUSAN SQUIRES (109), THERESA BERDOE-YOUNG (596)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection inspection.

This inspection was conducted on the following date(s): September 11, 12, 15, 16, 17, 19, 22, 23, 24, 25, 26, 29, 30, and October 1, 2, 2014

During the course of the inspection, the following critical incident, complaint and follow-up inspections were completed: T-760-14, T-502-14, T-697-14, T-838-14, T-503-14, T-289-13, T-504-14.

During the course of the inspection, the inspector(s) spoke with the executive director-interim, director of care, nursing consultant, office manager, programs manager, environmental services manager, dietary manager, registered nursing staff, personal support workers (PSW), social worker, physiotherapist, support services manager, maintenance supervisor, quality assurance coordinator/nursing clerk, housekeeping aides, dietary aides, recreation aides, Residents' Council president, Family Council president, family members and residents.

During the course of the inspection, the inspector(s) conducted a tour of all home areas, observed meal services, reviewed clinical records, observed the provision of care, reviewed Residents' Council minutes and Family Council minutes, home's specific policies and procedures, air temperature logs, preventative maintenance schedules, recreation calendar and the complaint log.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Recreation and Social Activities
Residents' Council
Safe and Secure Home
Skin and Wound Care
Sufficient Staffing

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound care.

Record review and observation revealed resident 80 has multiple areas of altered skin integrity. The home uses three different clinical assessment tools for altered skin integrity. A Skin tear was discovered on an identified date and was not assessed using the home's assessment tool after 18 days.

Record review and staff interview revealed that none of the home's assessment tools were completed for three identified dates for three different identified areas of altered skin integrity. [s. 50. (2) (b) (i)]

2. Record review revealed on an identified date that resident 82's family member found a healed skin tear on the resident's specific body area that was covered with a protective dressing. The family member asked the nurse to look into the origin of the wound. The nurse did not find when the wound was first found and treated because there was no documentation on the health record.

Record review and staff interview revealed that there was no assessment completed using the home's assessment tool for this skin tear until the next day after the wound was found by the family member [s. 50. (2) (b) (i)]

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff.

Record review and observation revealed resident 80 has multiple areas of altered skin integrity.

Record review and staff interview revealed that weekly skin assessments were not completed for eight different dates for different identified areas of altered skin integrity. [s. 50. (2) (b) (iv)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 3. Residents' Bill of Rights

Specifically failed to comply with the following:

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
3. Every resident has the right not to be neglected by the licensee or staff. 2007, c. 8, s. 3 (1).

s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:
11. Every resident has the right to,
i. participate fully in the development, implementation, review and revision of his or her plan of care,
ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,
iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and
iv. have his or her personal health information within the meaning of the Personal Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act. 2007, c. 8, s. 3 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity was fully respected and promoted.

On an identified date, the inspector observed an identified staff member to raise his/her voice to resident 84 telling the resident that the staff are not here on the resident's time.

Interview with resident 84 revealed that this was not the first occurrence of staff not treating her/him with courtesy and respect. The resident stated that there was one other occasion when a staff member stated to her/him "we are not your servants". The resident did not report this to anyone. Resident stated that she/he felt bad when the staff spoke to him/her in this manner and felt like she/he is supposed to apologize to the staff. [s. 3. (1) 1.]

2. The licensee has failed to ensure that every resident has the right not to be neglected by the licensee or staff.

On an identified date, the family member of resident 62 discovered the resident's brief to be saturated in urine.
Record review of the home's investigation notes and interview with the nursing consultant indicated that resident 62's brief was not changed for five hours. The home considered this an incidence of neglect. [s. 3. (1) 3.]

3. The licensee has failed to ensure every resident's right to have his or her personal health information with in the meaning of the Personal Health Information Protection Act, 2004 is kept confidential in accordance with that Act, is fully respected and promoted.

On an identified day during the medication administration pass on a unit, the inspector observed medication pouches with residents personal health information visible (name, room number, name of medication prescribed) in the garbage of the medication cart. The medication pouches were visible to anyone passing by. Another incident was observed later after lunch time where four empty medication pouches were visible with residents' personal health information. Interview with three identified registered staff confirmed that residents' empty medication pouches are always discarded in the medication cart garbage containers. [s. 3. (1) 11. iv.]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that resident 84's right to be treated with courtesy and respect and in a way that fully recognizes individuality and respects dignity is fully respected and promoted, resident's 62's not to be neglected by the licensee or staff, and every resident's personal health information with in the meaning of the Personal Health Information Protection Act, 2004 is kept confidential in accordance with that Act, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 5. Every licensee of a long-term care home shall ensure that the home is a safe and secure environment for its residents. 2007, c. 8, s. 5.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is a safe and secure environment for its residents.

On September 11, 2014, the second floor Activities Room was observed to have a pool of water on the floor posing a trip hazard to residents. After identification by the inspector, staff confirmed the hazard and cleaned the water. On September 11, 2014, in the third floor lounge area a metal mantel for a fireplace was observed to be standing on the floor bedside the television not affixed to the wall. The staff confirmed that the mantel should not have been on the floor and posed a safety risk to residents. [s. 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home is a safe and secure environment for its residents, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (2) The licensee shall ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of that resident. 2007, c. 8, s. 6 (2).

s. 6. (4) The licensee shall ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other,
(a) in the assessment of the resident so that their assessments are integrated and are consistent with and complement each other; and 2007, c. 8, s. 6 (4).
(b) in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other. 2007, c. 8, s. 6 (4).

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that there is a written plan of care for each resident that sets out the planned care for the resident.

On an identified date, resident 35 was provided lunch in his/her room. Interview with staff revealed that the resident consumes the majority of the meals in his/her room related to the management of an identified behaviour. A review of the written plan of care did not specify the resident consuming meals in his/her room. Interview with registered staff confirmed that the intervention was not outlined in the written plan of care. [s. 6. (1) (a)]

2. Record review of resident 33's care plan with identified staff revealed that there were no goals and interventions to direct staff regarding oral care. During interview with resident 33, resident confirmed that she/he can complete his/her own mouth care, and staff will do it at times, but she/he only wants it done once daily. The written plan of care does not specify that resident is independent with oral care and requires it to be done once a day. [s. 6. (1) (a)]

3. The licensee failed to ensure that there is a written plan of care for each resident that sets out clear directions to staff and others who provide direct care to the resident.
The plan of care for resident 22 provided conflicting direction to the staff in two different sections. Under the assistive devices section the plan indicated for staff to provide the resident with a straw for fluids, and under a subsequent section the speech language pathology (SLP) recommendations stated that the resident should not be provided with straws. The diet list located in the servery directed staff to provide straws for the resident. The resident was observed in his/her room during afternoon snack on an idendified date, to be consuming two glasses of fluids with straws. On the same day at lunch the resident was not provided straws for the fluids served. Interviews with registered staff and the dietary manager revealed that the resident should not receive straws as per a recent SLP assessment and confirmed that the written plan of care did not provide clear directions to the staff regarding the straws. [s. 6. (1) (c)]

4. The written plan of care for resident 22 directed staff to provide the resident with 125 ml Ensure Plus at morning, afternoon and evening snack, as well as 2 soft cookies at morning and evening snacks. Interviews with PSWs revealed that the resident was receiving a milkshake at morning snack. A review of the nourishment labels revealed that the morning snack label for the resident indicated milkshake. Interview with the dietary manager confirmed that the written plan of care and the snack label directed the staff to provide different supplements for morning snack, and did not provide clear directions to the staff. [s. 6. (1) (c)]

5. Staff interview and record review revealed resident 9 has a pressure ulcer to a specific area on her/his body which re-opened on an identified date. Record review revealed the plan of care had been changed seven days after, by the dietitian to reflect nutritional changes. The problem statement on the revised plan of care still indicated that the pressure ulcer had a potential to re-open and that the resident had an abrasion to another area of the body. There was no abrasion on that area and the pressure ulcer was an actual problem and not a potential problem.
The new plan of care was placed along with the existing plan of care and inserted with the PSW assignment binder. The previous plan had an uneven line drawn across several of the problem statements.
Interview with the registered nurse revealed that when the plan of care is revised by any of the disciplines, the whole plan of care must be printed off for the PSW's to follow.
The plan of care for resident 9's pressure ulcer lacked clear direction to the staff and others who provide direct care to the resident. [s. 6. (1) (c)]

6. Record review of the written plan of care completed on an identified date, indicated that two staff should toilet resident 62 using a sit to stand lift to transfer her/him to the toilet. Another area of the written plan of care indicated to pivot transfer the resident and provide extensive assistance with two staff. Interview with identified staff and DOC confirmed that the written plan of care does not provide clear direction to staff on how to transfer the resident during toileting.

Record review of the written plan of care completed on an identified date, indicated that resident 62 should be toileted at 07:30, 11:30, 15:30 and 19:00. Another area of the written plan of care indicated to toilet the resident when she/he is awake, approximately 11:30 am, after dinner and between 6:30 pm to 7:00 pm. Interview with the DOC confirmed that the toileting schedule in the written plan of care does not provide clear direction to staff. [s. 6. (1) (c)]

7. The licensee failed to ensure that the care set out in the plan of care is based on an assessment of the resident and the needs and preferences of the resident.

A Recreation Custom Assessment completed for resident 34 on an identified date, indicated that the resident likes dogs and other animals, likes to read and does not like music. Eight months later, the Minimum Data Set (MDS) assessment identified the following general activity preferences for the resident: reading or writing, trips or

shopping, walk/wheeling outdoors, and watching TV. A review of the resident's plan of care only directed staff to sit with the resident and to tell him/her comforting stories. Interviews with staff confirmed that the recreation plan of care was not based on the assessments of the resident's needs and preferences. [s. 6. (2)]

8. The licensee has failed to ensure that the staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other.

Record review revealed that on an identified day, resident 80 developed an area described as redness/bruising to a specific area on the body. The treatment intervention identified on the treatment records indicated the wound care nurse would assess the area every Wednesday.

Interview with the wound care nurse revealed that she/he was not notified of the need to assess this alteration in skin integrity and did not assess the resident as indicated on the treatment record. The wound care nurse did not receive a referral to complete an assessment on the resident. [s. 6. (4) (a)]

9. Resident 85's assessment by the registered dietitian revealed resident requires nutritional supplement to be given three times a day, and one tablespoon of seed powder to be given with the cereal every day.
Interview of the nursing staff revealed that the staff have been only giving the supplement once a day in the evening, and have not been giving the seed powder on the cereal because the resident doesn't like the look of the seeds and does not want the supplement.
Interview with the registered dietitian revealed that the staff have not collaborated with her/him to ensure that the RD is part of the assessment of resident 85's nutritional care. [s. 6. (4) (a)]

10. The licensee failed to ensure that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other.

The written plan of care for resident 22 directed staff to provide the resident with a lip plate, built up fork and spoon, straw for fluids or a kennedy cup as assistive devices at meals. The resident was observed to be served lunch and was only provided the

lipped plate. The inspector pointed out the discrepancy with the registered staff who then updated the care plan removing the built up fork and spoon, straw for fluids or a kennedy cup as assistive devices at meals, indicating that the resident did not use these devices and that the SLP had recommended the resident not use straws. Interview with the dietary manager revealed that the registered staff should have referred to the registered dietitian (RD) for reassessment. The registered staff did not collaborate with the RD in development and implementation of the resident's plan of care. [s. 6. (4) (b)]

11. Record review indicated that resident 62 had a fall on an identified date and a post-fall assessment was completed. Record review and interview with the nursing consultant revealed that the post-fall assessment indicated to put the resident's bed at the lowest position, place a floor mattress at the bedside, and resident was to wear no slip foot wear. These interventions were not implemented in the resident's written plan of care during that time period. [s. 6. (4) (b)]

12. The licensee failed to ensure that the care set out in the plan is provided to the resident as specified in the plan.
During the lunch meal observation on an identified date, resident 51 was observed to receive one serving of soup and one serving of dessert. The diet list located in the servery and the resident's written plan of care directed staff to provide the resident two servings of soup and two servings of dessert. Staff confirmed that the resident was not provided two servings of soup or dessert as per the resident's plan of care. [s. 6. (7)]

13. During the lunch meal observation on an identified date, resident 38 was observed to receive a specific dessert. The diet list located in the servery directed staff not to provide the resident with that specific dessert. Registered staff confirmed that the resident should not have been provided with that specific dessert due to a medical condition. [s. 6. (7)]

14. Record review of the written plan of care for urinary incontinence completed on an identified date, indicated that resident 62 should be checked every two to three hours for wetness or if she/he needs to use the toilet.
Record review and interview with the identified staff revealed that the staff member was not aware of the written plan of care prior to providing care for resident and did not follow the toileting routine. The resident was found with a brief saturated in urine late during the evening.

Interview with the DOC confirmed that the resident was not provided with the toileting routine as set out in the plan of care. [s. 6. (7)]

15. Resident 85's medical plan of care includes administration of two medications at 8:00 am and 4:00 pm. Observation and staff interview revealed the medications prescribed for 8:00 am are not consistently administered to the resident until 12:00 pm, followed by the next dose of medication at 4:00 pm. [s. 6. (7)]

16. The licensee failed to ensure that each resident is offered a minimum of three meals daily.
On an identified date, interview with resident 85's family member revealed that she/he arrived at the home at 12 pm, and found the breakfast tray sitting on a table across the resident's room. The food and tray had not been touched. The plan of care indicates resident 85 requires total assistance to consume his/her meal and did not receive assistance on that day. [s. 6. (7)]

17. Record review of the nutritional plan of care directs the staff to provide one tablespoon of seed in breakfast cereal. The plan for snacks directs the staff to give 125 ml of supplement, three times a day for nutritional support. The nutritional plan of care was ordered by the registered dietitian.
Interview with the staff revealed the supplement is only given to the resident once a day in the evening.
Observation of care revealed the resident did not receive the seed powder on an identified date. Interview with staff revealed the resident has only received the seed powder once in the past 11 days. [s. 6. (7)]

18. The plan of care for resident 85 directs the staff to wake the resident up at 7:45 am and the resident likes to have a nap at 9:30 am to 11:45 am and again from 1:30 pm to 3:30 pm.
On an identified date at 9:15 am the resident was observed to be lying in bed awake and calling out for someone. The resident remained awake in bed until 10:35 am when the assigned PSW assisted the resident out of bed and brought him/her to the dining room for the breakfast meal. The plan of care for sleep pattern preferences was not followed. [s. 6. (7)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the plan of care complies with the following:

- ***that sets out the planned care for the resident,***
- ***that sets out clear directions to staff and others who provide direct care to the resident,***
- ***is based on an assessment of the resident and the needs and preferences of the resident,***
- ***that the staff and others involved in the different aspects of care collaborate with each other in the assessment of the resident so that their assessments are integrated, consistent with and complement each other,***
- ***that the staff and others involved in the different aspects of care of the resident collaborate with each other in the development and implementation of the plan of care so that the different aspects of care are integrated and are consistent with and complement each other,***
- ***that the care set out in the plan is provided to the resident as specified in the plan,, to be implemented voluntarily.***

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 9. Doors in a home

Specifically failed to comply with the following:

s. 9. (1) Every licensee of a long-term care home shall ensure that the following rules are complied with:
2. All doors leading to non-residential areas must be equipped with locks to restrict unsupervised access to those areas by residents, and those doors must be kept closed and locked when they are not being supervised by staff. O. Reg. 79/10, s. 9; O. Reg. 363/11, s. 1 (1, 2).

Findings/Faits saillants :

1. The licensee failed to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff.

On September 11, 2014, the following doors were observed unlocked on the second floor of the home: Health & Safety room door, two Clean Utility rooms with various personal hygiene products and razors, one Housekeeping room with Everyday Disinfectant, two Soiled Utility rooms with Accel TB wipes and soiled laundry. Staff confirmed that each of these doors leads to non-residential areas and should be kept locked when they are not being supervised by staff. [s. 9. (1) 2.]

2. On September 12 and 19, 2014, on the second floor of the home, two Clean Utility rooms with various personal hygiene products and razors were observed to be unlocked. [s. 9. (1) 2.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all doors leading to non-residential areas are kept closed and locked when they are not being supervised by staff, to be implemented voluntarily.

WN #6: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 15. Accommodation services

Specifically failed to comply with the following:

s. 15. (2) Every licensee of a long-term care home shall ensure that,
(a) the home, furnishings and equipment are kept clean and sanitary; 2007, c. 8, s. 15 (2).
(b) each resident's linen and personal clothing is collected, sorted, cleaned and delivered; and 2007, c. 8, s. 15 (2).
(c) the home, furnishings and equipment are maintained in a safe condition and in a good state of repair. 2007, c. 8, s. 15 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents' equipment is kept clean and sanitary.

On an identified date, the inspector observed resident 22's wheelchair with seat and arm rests very dirty, and walker dirty with old dried white marks on it. The inspector observed resident 27's wheelchair in his/her room, with dirty armrests.
The next day, the inspector observed resident 22's wheelchair and walker to be cleaned, while resident 27's wheelchair armrests remained dirty.

Interview with identified registered staff and record review of wheelchair cleaning schedule and sign off documentation showed January 2014 to present missing in binder. One documentation sign off sheet for the week of an identified month confirmed when resident #22's wheelchair was most recently cleaned, then not again until five months later. Interview and record review of wheelchair cleaning schedule and sign off documentation with an identified registered staff revealed that resident #27's wheelchair wasn't cleaned for 13 days on an identified month. Interview with DOC confirmed that her expectation is that resident wheelchairs are cleaned nightly by the PSWs who work on the night shift, and it is the registered staffs responsibility to ensure that it is completed. [s. 15. (2) (a)]

2. On an identified date at 3:40 pm, the inspector observed an orange color liquid substance, which appeared to be emesis in one of the spa rooms in the home. The inspector also observed a dirty floor with brown stains beside resident 23's bed, in front of the window, and near resident's bathroom. On the next day, the inspector observed that the orange liquid substance still remained on the spa room floor. Interview with identified housekeeping aide revealed that she/he did mop the spa room on the next day, but missed cleaning the area.
On that day, the inspector observed that resident 23's room floor remained dirty. Observation and interview with identified staff revealed that she/he cleaned and mopped resident 23's room on that same day, but indicated that the resident's room is challenging to keep clean. [s. 15. (2) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that residents' equipment is kept clean and sanitary, to be implemented voluntarily.

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 17. Communication and response system

Specifically failed to comply with the following:

s. 17. (1) Every licensee of a long-term care home shall ensure that the home is equipped with a resident-staff communication and response system that,
(a) can be easily seen, accessed and used by residents, staff and visitors at all times; O. Reg. 79/10, s. 17 (1).
(b) is on at all times; O. Reg. 79/10, s. 17 (1).
(c) allows calls to be cancelled only at the point of activation; O. Reg. 79/10, s. 17 (1).
(d) is available at each bed, toilet, bath and shower location used by residents; O. Reg. 79/10, s. 17 (1).
(e) is available in every area accessible by residents; O. Reg. 79/10, s. 17 (1).
(f) clearly indicates when activated where the signal is coming from; and O. Reg. 79/10, s. 17 (1).
(g) in the case of a system that uses sound to alert staff, is properly calibrated so that the level of sound is audible to staff. O. Reg. 79/10, s. 17 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident-staff communication and response system is easily used by the resident, staff and visitors at all times.

The call bells in the bathroom for four rooms were difficult to activate and the call bell cord for one bathroom was broken. Inspector and identified staff observed that the call bell required moderate force to be activated. One room's call bell did not activate with moderate force by the inspector. [s. 17. (1) (a)]

2. On an identified date, the inspector observed that resident 12's call system above his/her bed was not functioning. Interview with an identified PSW revealed that he/she was not aware of the nonfunctioning call system. On the same day, the identified PSW contacted maintenance and the
inspector observed that the call system was repaired. On an identified date, the inspector observed that resident 16's call system above his/her bed was not functioning. Interview with an identified staff revealed that he/she was not aware of the nonfunctioning call system. Three days later, the inspector observed that the call system was repaired. Interview with the identified various staff confirmed that the call system was repaired on the day that it was observed not functioning. [s. 17. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the resident-staff communication and response system is easily used by the resident, staff and visitors at all times, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with O.Reg 79/10, s. 34. Oral care

Specifically failed to comply with the following:

s. 34. (1) Every licensee of a long-term care home shall ensure that each resident of the home receives oral care to maintain the integrity of the oral tissue that includes,
(a) mouth care in the morning and evening, including the cleaning of dentures; O. Reg. 79/10, s. 34 (1).
(b) physical assistance or cuing to help a resident who cannot, for any reason, brush his or her own teeth; and O. Reg. 79/10, s. 34 (1).
(c) an offer of an annual dental assessment and other preventive dental services, subject to payment being authorized by the resident or the resident's substitute decision-maker, if payment is required. O. Reg. 79/10, s. 34 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents are offered an annual dental assessment.
Record review of resident 31 and 33's plans of care revealed no record of dental screening in 2013.
Interview with an identified registered staff revealed that the last time a dental screening was offered for all residents was January 24, 2012, by the Public Health.
Interview with the nursing consultant revealed that an annual dental assessment was not offered to residents in 2013. [s. 34. (1) (c)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the residents are offered an annual dental assessment, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with O.Reg 79/10, s. 49. Falls prevention and management

Specifically failed to comply with the following:

s. 49. (2) Every licensee of a long-term care home shall ensure that when a resident has fallen, the resident is assessed and that where the condition or circumstances of the resident require, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls. O. Reg. 79/10, s. 49 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that when a resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls.

Record reviews and interview with identified staff indicated that resident 62 had a fall on an identified date, and a post-fall assessment was not conducted using a clinically appropriate assessment instrument. [s. 49. (2)]

2. Record review indicated that resident 61 had a fall on an identified date. Record review and interview with identified staff confirmed that a post-fall assessment was not conducted using a clinically appropriate assessment. [s. 49. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that when a resident has fallen, the resident is assessed and, if required, a post-fall assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for falls, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 71. Menu planning

Specifically failed to comply with the following:

s. 71. (1) Every licensee of a long-term care home shall ensure that the home's menu cycle,
(f) is reviewed by the Residents' Council for the home; and O. Reg. 79/10, s. 71 (1).

s. 71. (4) The licensee shall ensure that the planned menu items are offered and available at each meal and snack. O. Reg. 79/10, s. 71 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's menu cycle is reviewed by the Residents' Council for the home.

Review of the Resident's Council minutes and staff interview revealed that the menu cycle was not reviewed by Residents' Council [s. 71. (1) (f)]

2. The licensee failed to ensure that the planned menu items are offered.
Resident 52 required tray service for lunch on an identified date. The resident was delivered an entrée, dessert and beverages to his/her room and was not provided soup. Staff confirmed the resident was not provided the soup as per the planned menu and retrieved it from the servery for the resident. [s. 71. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's menu cycle is reviewed by the Residents' Council for the home, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with O.Reg 79/10, s. 90. Maintenance services

Specifically failed to comply with the following:

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(b) all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, excluding the residents' personal aids or equipment; O. Reg. 79/10, s. 90 (2).

s. 90. (2) The licensee shall ensure that procedures are developed and implemented to ensure that,
(d) all plumbing fixtures, toilets, sinks, grab bars and washroom fixtures and accessories are maintained and kept free of corrosion and cracks; O. Reg. 79/10, s. 90 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that procedures are developed and implemented to make sure all equipment, devices, assistive aids and positioning aids in the home are kept in good repair.

Interview with an identified staff and observation made on an identified date, revealed that the toilet grab bars in resident 16's washroom were found to be loose and unstable. Three days later, interview and observation with an identified staff indicated that the toilet grab bars in resident's washroom were not repaired. He/she stated that the maintenance supervisor will be informed and the resident using the bathroom will be reassessed to determine the need for toilet grab bars. Interview with the maintenance supervisor and the support services manager confirmed that the toilet grab bars were removed on that day and the resident did not use the bathroom. [s. 90. (2) (b)]

2. The licensee has failed to ensure that procedures are implemented to ensure that washroom fixtures are maintained and kept free of corrosion and cracks.

On September 12, 2014, the inspector observed four broken tiles in the first floor spa room on the Kingsway unit.
Observation and interview with Maintenance Supervisor confirmed that the home was not aware of the four broken tiles in the spa room and the need for repair because no one had completed a work order. [s. 90. (2) (d)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that procedures are developed and implemented to make sure all equipment, devices, assistive aids and positioning aids in the home are kept in good repair, and that procedures are implemented to ensure that washroom fixtures are maintained and kept free of corrosion and cracks, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with O.Reg 79/10, s. 91. Every licensee of a long-term care home shall ensure that all hazardous substances at the home are labelled properly and are kept inaccessible to residents at all times. O. Reg. 79/10, s. 91.

Findings/Faits saillants :

1. The licensee failed to ensure that all hazardous substances at the home are kept inaccessible to residents at all times.

On September 11, 2014, the three resident laundry rooms located on the second and third floors were observed to have Tri-Star Flexylite detergent stored in unlocked cabinets. The manufacturer's label indicated that the product could cause severe skin burns and eye damage. Staff confirmed that the cabinets containing the detergent should be locked. The housekeeping room on the second floor, room 2219, was observed to be unlocked and contained Everyday Disinfectant. The manufacturer's label indicated that the product was very toxic, highly irritating and corrosive. Staff confirmed that the door to the housekeeping room should be locked to prevent residents from accessing the disinfectant. [s. 91.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that all hazardous substances at the home are kept inaccessible to residents at all times, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

s. 229. (10) The licensee shall ensure that the following immunization and screening measures are in place:
1. Each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee. O. Reg. 79/10, s. 229 (10).

s. 229. (12) The licensee shall ensure that any pet living in the home or visiting as part of a pet visitation program has up-to-date immunizations. O. Reg. 79/10, s. 229 (12).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff participate in the implementation of the infection control program.

On an identified date, the inspector observed seven unlabelled resident nail clippers stored in one of the spa room in the home. Interview with identified PSW and the DOC revealed that the residents' nail clippers should be labelled. [s. 229. (4)]

2. The licensee failed to ensure that each resident admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee.

Record review indicated that resident 64 admitted on an identified date, was not screened for tuberculosis within 14 days of admission, and there was no screening for tuberculosis done 90 days prior to admission.
Interview with the DOC confirmed that the screening for tuberculosis was not completed within 14 days of admission or 90 days prior to admission. [s. 229. (10) 1.]

3. The licensee failed to ensure that the pets visiting as part of a pet visitation program have up-to-date immunizations.

Reviews of the vaccination records indicated that two pet immunizations records visiting the home were not kept up-to-date.
Interview with the resident programs manager confirmed that the pets' immunizations were not up-to-date. [s. 229. (12)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff participate in the implementation of the infection control program, that each residents admitted to the home must be screened for tuberculosis within 14 days of admission unless the resident has already been screened at some time in the 90 days prior to admission and the documented results of this screening are available to the licensee, and that the pet visiting as part of a pet visitation program has up-to-date immunizations, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails
Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that where bed rails are used the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident.

Resident 25 was observed in bed with one bed rail raised. Interviews with staff confirmed that the bed rail is used while the resident is in bed to ensure safety during care. A review of clinical records revealed that the resident had not been assessed for the use of bed rails and that the care plan did not include these interventions. Interviews with the corporate nursing consultant confirmed that the assessment had not been completed. [s. 15. (1) (a)]

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 21. Every licensee of a long-term care home shall ensure that the home is maintained at a minimum temperature of 22 degrees Celsius. O. Reg. 79/10, s. 21.

Findings/Faits saillants :

1. The licensee failed to ensure that the home is maintained at a minimum temperature of 22 degrees Celsius.

Interviews with residents 25 and 34 revealed that their rooms are too cold. Interview with the environmental services manager and sample temperature readings using the homes laser thermometer revealed on an identified date, resident 25's room temperature was 20.3 degrees Celsius and resident 34's room temperature was 20.8 degrees Celsius. Additionally, six randomly selected residents' rooms on two of the home's unit areas varied in temperature from 18.2 to 19.6 degrees Celsius and seven of the randomly selected residents' rooms on two other areas in the home varied in temperature from 18.9 to 20.6 degrees Celsius. Staff interview confirmed that the laser thermostat instrument used to measure the home's temperature found the aforementioned residents' rooms to be below 22 degrees Celsius. [s. 21.]

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
12. Dental and oral status, including oral hygiene. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee has failed to ensure that the plan of care is based on an interdisciplinary assessment of the resident's dental and oral status, including oral hygiene.

Resident 85 has a responsive behaviour. Baycrest Behavioural Support Ontario (BSO) assessed the resident's behavior and made recommendations to control the behaviour including providing mouth care to the resident when she/he wakes up, before and after meals and snacks, and before bedtime.

The written plan of care directs staff to provide mouth care in the morning and at bedtime only. Interview with the registered nursing staff confirmed that the plan of care was not based on the assessment of the BSO. [s. 26. (3) 12.]

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that any actions taken with respect to a resident under a program, including assessments, interventions and the resident's responses to interventions are documented.

Interviews with an identified activity aide and the programs manager revealed that resident 34 enjoys participating in the pet therapy program. Review of resident 34's activity attendance record did not reveal participation in this program. Interview with the programs manager revealed that the participation in this activity should be recorded on the resident's participation record, either as pet therapy or one to one visits with a notation indicating pet therapy. [s. 30. (2)]

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that each resident who is incontinent has an individualized plan of care to promote and manage bowel and bladder continence based on the assessment, and that the plan is implemented.
Review of the quarterly review assessment completed on an identified date, indicated that resident 15, had multiple daily episodes of bladder incontinence, used pads or briefs and there was no change in urinary continence in the last 14 days.

Record review of the written plan of care completed on the same identified date, indicated that resident 15 requires one or two staff to check and change the incontinence product when she/he is wet or soiled.

Interview with two identified staff confirmed that the written plan of care does not provide an individualized plan of care to promote and manage bladder continence. [s. 51. (2) (b)]

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 72. Food production

Specifically failed to comply with the following:

s. 72. (7) The licensee shall ensure that the home has and that the staff of the home comply with,
(b) a cleaning schedule for all the equipment; and O. Reg. 79/10, s. 72 (7).

Findings/Faits saillants :

1. The licensee failed to ensure that the home has and that the staff of the home comply with a cleaning schedule for the food production, servery and dishwashing areas.

The Daily Cleaning schedule in the Kitchen, which outlined the cleaning tasks for the main kitchen, directed staff to clean the steamer and combi oven daily. The steamer was signed as being cleaned on an identified date, and the combi oven was not signed as being clean. Observation of the steamer and combi oven on the next day revealed significant debris. An interview with the dietary manager confirmed that the equipment had not been cleaned the previous day and that the schedule had not been complied with.

The Servery Daily Cleaning Schedule, which outlined the cleaning tasks for the servery on the third floor, directed staff to clean the microwave inside and out daily. These tasks were signed as being cleaned on an identified date. Observation of the two microwaves on the third floor on the next day, revealed significant food debris. An interview with the dietary manager confirmed that the microwaves had not been cleaned the previous day and that the schedule had not been complied with. [s. 72. (7) (b)]

WN #20: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
2. Review, subject to compliance with subsection 71 (6), of meal and snack times by the Residents' Council. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
6. Food and fluids being served at a temperature that is both safe and palatable to the residents. O. Reg. 79/10, s. 73 (1).

s. 73. (1) Every licensee of a long-term care home shall ensure that the home has a dining and snack service that includes, at a minimum, the following elements:
8. Course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs. O. Reg. 79/10, s. 73 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the home's dining and snack service includes review of meal and snack times by Residents' Council.

Review of the Resident's Council minutes and staff interview revealed that the meal and snack times were not reviewed by the Residents' Council. [s. 73. (1) 2.]

2. The licensee failed to ensure that the home has a dining and snack service that includes foods and fluids being served at a temperature that is both safe and palatable to the residents.

During the lunch observation on an identified date, a dish of ice cream was observed to be sitting on a cart at room temperature for 18 minutes prior to being served to a resident. The ice cream was observed to be melted at time of service to the resident. Interview with the dietary manager revealed that the ice cream should have been kept in the freezer until the time of service to the resident and that ice cream was not served at a palatable temperature. [s. 73. (1) 6.]

3. The licensee failed to ensure that the home has a dining and snack service that includes course by course service of meals for each resident, unless otherwise indicated by the resident or by the resident's assessed needs.

During the lunch meal observation on an identified date, resident 22 was observed to receive dessert while consuming the main course of the meal. The resident was not observed to indicate this as a preference. The care plan for the resident did not indicate exceptions to course by course meal service. The home's Meal Service policy, RESI-05-02-09 version November 2013, directs staff to serve residents meals course by course unless otherwise indicated by resident's assessed needs/preferences. An interview with dietary manager confirmed that the resident should have been served the meal course by course. [s. 73. (1) 8.]

WN #21: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 85. Satisfaction survey

Specifically failed to comply with the following:

s. 85. (4) The licensee shall ensure that,
(a) the results of the survey are documented and made available to the Residents' Council and the Family Council, if any, to seek their advice under subsection (3); 2007, c. 8, s. 85. (4).
(b) the actions taken to improve the long-term care home, and the care, services, programs and goods based on the results of the survey are documented and made available to the Residents' Council and the Family Council, if any; 2007, c. 8, s. 85. (4).
(c) the documentation required by clauses (a) and (b) is made available to residents and their families; and 2007, c. 8, s. 85. (4).
(d) the documentation required by clauses (a) and (b) is kept in the long-term care home and is made available during an inspection under Part IX. 2007, c. 8, s. 85. (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the satisfaction survey are documented and made available to the Residents' Council.

Review of the Resident's Council minutes and interviews with staff and the Residents' Council president revealed that the results of the 2013 satisfaction survey were not made available to the Residents' Council. [s. 85. (4) (a)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 123.
Emergency drug supply
Every licensee of a long-term care home who maintains an emergency drug supply for the home shall ensure,
(a) that only drugs approved for this purpose by the Medical Director in collaboration with the pharmacy service provider, the Director of Nursing and Personal Care and the Administrator are kept;
(b) that a written policy is in place to address the location of the supply, procedures and timing for reordering drugs, access to the supply, use of drugs in the supply and tracking and documentation with respect to the drugs maintained in the supply;
(c) that, at least annually, there is an evaluation done by the persons referred to in clause (a) of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs; and
(d) that any recommended changes resulting from the evaluation are implemented. O. Reg. 79/10, s. 123.

Findings/Faits saillants :

1. The licensee has failed to ensure that at least annually, there is an evaluation done by the Medical Director, pharmacy service provider, DOC and Administrator, of the utilization of drugs kept in the emergency drug supply in order to determine the need for the drugs.

Review of the Emergency Drug Box List on the 3rd floor showed no evidence of annual review or sign off by the Medical/Professional Advisory committee. Interview with DOC revealed that the home is unable to find documentation to support that annual review of emergency drug box medications and that it was not completed in 2013. [s. 123. (c)]

WN #23: The Licensee has failed to comply with O.Reg 79/10, s. 134. Residents' drug regimes

Every licensee of a long-term care home shall ensure that,

(a) when a resident is taking any drug or combination of drugs, including psychotropic drugs, there is monitoring and documentation of the resident's response and the effectiveness of the drugs appropriate to the risk level of the drugs;

(b) appropriate actions are taken in response to any medication incident involving a resident and any adverse drug reaction to a drug or combination of drugs, including psychotropic drugs; and

(c) there is, at least quarterly, a documented reassessment of each resident's drug regime. O. Reg. 79/10, s. 134.

Findings/Faits saillants :

1. The licensee failed to ensure that there is, at least quarterly, a documented reassessment of each resident's drug regime.

On and identified date, record of the Medication Review Report indicated that the resident 62's drug regime was assessed quarterly from the period of five months. The Medication Review Report indicated that the medication was not reviewed since the last day of the fifth month. The next quarterly medication report assessment is to be reviewed for the period of the next three months after 31 days of the last day of the fifth month.

Interview with an identified staff and the DOC confirmed that the resident's medication was not reviewed for 31 days. [s. 134. (c)]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 228.
Continuous quality improvement
Every licensee of a long-term care home shall ensure that the quality improvement and utilization review system required under section 84 of the Act complies with the following requirements:
1. There must be a written description of the system that includes its goals, objectives, policies, procedures and protocols and a process to identify initiatives for review.
2. The system must be ongoing and interdisciplinary.
3. The improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents must be communicated to the Residents' Council, Family Council and the staff of the home on an ongoing basis.
4. A record must be maintained by the licensee setting out,
i. the matters referred to in paragraph 3,
ii. the names of the persons who participated in evaluations, and the dates improvements were implemented, and
iii. the communications under paragraph 3. O. Reg. 79/10, s. 228.

Findings/Faits saillants :

1. The licensee failed to ensure that the home's quality improvement and utilization review system ensures that improvements made to the quality of the accommodation, care, services, programs and goods provided to the residents are communicated to the Residents' Council on an ongoing basis.

Interview with the Residents' Council president revealed that adjustable height dining tables had been purchased and placed in resident dining areas and that the Council had not been informed about this purchase. It was further revealed that residents had questions about whether all of the facilities dining tables would be replaced. Review of the Residents' Council minutes and interviews with staff confirmed that these improvements had not been communicated to the Residents' Council. [s. 228. 3.]

2. The licensee failed to ensure that a record of the communication made to the Residents' Council, Family Council and the staff of the home regarding the improvement made to the quality of the accommodation, care, services, programs and goods are provided to the residents.

Record review of the LTCH Licensee Confirmation Checklist Quality Improvement, and interview with the DOC and the administrator indicated that the licensee does not keep a record of the communication made to the Residents' Council, Family Council and the staff of the home regarding the improvement made to the quality of the accommodation, care, services, programs and goods provided to the residents. [s. 228. 4. i.]

THE FOLLOWING NON-COMPLIANCE AND/OR ACTION(S)/ORDER(S) HAVE BEEN COMPLIED WITH/
LES CAS DE NON-RESPECTS ET/OU LES ACTIONS ET/OU LES ORDRES SUIVANT SONT MAINTENANT CONFORME AUX EXIGENCES:

COMPLIED NON-COMPLIANCE/ORDER(S)
REDRESSEMENT EN CAS DE NON-RESPECT OU LES ORDERS

REQUIREMENT/ EXIGENCE	TYPE OF ACTION/ GENRE DE MESURE	INSPECTION # / NO DE L'INSPECTION	INSPECTOR ID #/ NO DE L'INSPECTEUR
LTCHA, 2007 S.O. 2007, c.8 s. 19. (1)	CO #001	2014_163109_0007	109

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Issued on this 29th day of October, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

J Taillefer RN

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	JOELLE TAILLEFER (211), LAURA BROWN-HUESKEN (503), SUSAN SQUIRES (109), THERESA BERDOE-YOUNG (596)
Inspection No. / No de l'inspection :	2014_219211_0019
Log No. / Registre no:	T-114-14
Type of Inspection / Genre d'inspection:	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Oct 23, 2014
Licensee / Titulaire de permis :	WEST PARK HEALTHCARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
LTC Home / Foyer de SLD :	WEST PARK LONG TERM CARE CENTRE 82 BUTTONWOOD AVENUE, TORONTO, ON, M6M-2J5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	TRISH TALABIS

Ontario

Ministry of Health and Long-Term Care

Ministére de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

To WEST PARK HEALTHCARE CENTRE, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Linked to Existing Order / Lien vers ordre existant: 2014_163109_0011, CO #001;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 50. (2) Every licensee of a long-term care home shall ensure that,

(a) a resident at risk of altered skin integrity receives a skin assessment by a member of the registered nursing staff,

(i) within 24 hours of the resident's admission,

(ii) upon any return of the resident from hospital, and

(iii) upon any return of the resident from an absence of greater than 24 hours;

(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,

(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,

(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and

(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated;

(c) the equipment, supplies, devices and positioning aids referred to in subsection (1) are readily available at the home as required to relieve pressure, treat pressure ulcers, skin tears or wounds and promote healing; and

(d) any resident who is dependent on staff for repositioning is repositioned every two hours or more frequently as required depending upon the resident's condition and tolerance of tissue load, except that a resident shall only be repositioned while asleep if clinically indicated. O. Reg. 79/10, s. 50 (2).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the areas identified in the grounds are corrected and includes the following actions:

Resident 80 and 82 exhibiting altered skin integrity including skin tears or wounds receive a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound care.

Resident 80 exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, is reassessed at least weekly by a member of the registered nursing staff.

Please submit plan to susan.squires@ontario.ca on or before November 14, 2014.

Grounds / Motifs :

1. Record review revealed on an identified date, that resident 82's family member found a healed skin tear on a specific area of the body that was covered with a protective dressing. The family member asked the nurse to look into the origin of the wound. The nurse did not find when the wound was first found and treated because there was no documentation on the health record. Record review and staff interview revealed that there was no assessment completed using the homes assessment tool for this skin tear until the next day, after the wound was found by the family member. (109)

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity including skin breakdown, pressure ulcers, skin tears or wounds received a skin assessment by a member of the registered nursing staff using a clinically appropriate assessment instrument that is specifically designed for skin and wound care.

Record review and observation revealed resident 80 has multiple areas of altered skin integrity. The home uses three different clinical assessment tools for altered skin integrity. Skin tear was discovered on an identified date and was not assessed using the home's assessment tool after 18 days later.

Record review and staff interview revealed that none of the home's assessment tools were completed on three different days for the three identified areas of altered skin integrity. (109)

3. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, has been reassessed at least weekly by a member of the registered nursing staff. Record review and observation revealed resident 80 has multiple areas of altered skin integrity. Record review and staff interview revealed that weekly skin assessments were not completed for eight different dates for the three identified areas of altered skin integrity. (109)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2014

Order # /
Ordre no : 002

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 3. (1) Every licensee of a long-term care home shall ensure that the following rights of residents are fully respected and promoted:

1. Every resident has the right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity.
2. Every resident has the right to be protected from abuse.
3. Every resident has the right not to be neglected by the licensee or staff.
4. Every resident has the right to be properly sheltered, fed, clothed, groomed and cared for in a manner consistent with his or her needs.
5. Every resident has the right to live in a safe and clean environment.
6. Every resident has the right to exercise the rights of a citizen.
7. Every resident has the right to be told who is responsible for and who is providing the resident's direct care.
8. Every resident has the right to be afforded privacy in treatment and in caring for his or her personal needs.
9. Every resident has the right to have his or her participation in decision-making respected.
10. Every resident has the right to keep and display personal possessions, pictures and furnishings in his or her room subject to safety requirements and the rights of other residents.
11. Every resident has the right to,

i. participate fully in the development, implementation, review and revision of his or her plan of care,

ii. give or refuse consent to any treatment, care or services for which his or her consent is required by law and to be informed of the consequences of giving or refusing consent,

iii. participate fully in making any decision concerning any aspect of his or her care, including any decision concerning his or her admission, discharge or transfer to or from a long-term care home or a secure unit and to obtain an independent opinion with regard to any of those matters, and

iv. have his or her personal health information within the meaning of the Personal

Health Information Protection Act, 2004 kept confidential in accordance with that Act, and to have access to his or her records of personal health information, including his or her plan of care, in accordance with that Act.

12. Every resident has the right to receive care and assistance towards independence based on a restorative care philosophy to maximize independence to the greatest extent possible.

13. Every resident has the right not to be restrained, except in the limited circumstances provided for under this Act and subject to the requirements provided for under this Act.

14. Every resident has the right to communicate in confidence, receive visitors of his or her choice and consult in private with any person without interference.

15. Every resident who is dying or who is very ill has the right to have family and friends present 24 hours per day.

16. Every resident has the right to designate a person to receive information concerning any transfer or any hospitalization of the resident and to have that person receive that information immediately.

17. Every resident has the right to raise concerns or recommend changes in policies and services on behalf of himself or herself or others to the following persons and organizations without interference and without fear of coercion, discrimination or reprisal, whether directed at the resident or anyone else,

i. the Residents' Council,

ii. the Family Council,

iii. the licensee, and, if the licensee is a corporation, the directors and officers of the corporation, and, in the case of a home approved under Part VIII, a member of the committee of management for the home under section 132 or of the board of management for the home under section 125 or 129,

iv. staff members,

v. government officials,

vi. any other person inside or outside the long-term care home.

18. Every resident has the right to form friendships and relationships and to participate in the life of the long-term care home.

19. Every resident has the right to have his or her lifestyle and choices respected.

20. Every resident has the right to participate in the Residents' Council.

21. Every resident has the right to meet privately with his or her spouse or another person in a room that assures privacy.

22. Every resident has the right to share a room with another resident according to their mutual wishes, if appropriate accommodation is available.

23. Every resident has the right to pursue social, cultural, religious, spiritual and

other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential.

24. Every resident has the right to be informed in writing of any law, rule or policy affecting services provided to the resident and of the procedures for initiating complaints.

25. Every resident has the right to manage his or her own financial affairs unless the resident lacks the legal capacity to do so.

26. Every resident has the right to be given access to protected outdoor areas in order to enjoy outdoor activity unless the physical setting makes this impossible.

27. Every resident has the right to have any friend, family member, or other person of importance to the resident attend any meeting with the licensee or the staff of the home. 2007, c. 8, s. 3 (1).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that the following resident rights are fully respected and promoted:
Resident 84's right to be treated with courtesy and respect and in a way that fully recognizes the resident's individuality and respects the resident's dignity and
Resident 62's right not to be neglected by the licensee or staff.
Please submit compliance plan to joelle.taillefer@ontario.ca on or before November 14, 2014.

Grounds / Motifs :

1. LTCHA s. 3(1) has been the subject of a previous compliance order to the licensee with a compliance date of June 16, 2014 (inspection #2014_163109_0010 from April 11, 2014).

1. The licensee has failed to ensure that the resident's right to be treated with courtesy and respect and in a way that fully recognizes his/her individuality and respects his/her dignity was fully respected and promoted.
On an identified date, the inspector observed an identified staff member to raise his/her voice to resident 84 telling the resident that the staff are not here on the resident's time.
Interview with resident 84 revealed that this was not the first occurrence of staff not treating him/her with courtesy and respect. The resident stated that there was one other occasion when a staff member stated to him/her "we are not your servants". The resident did not report this to anyone. Resident stated that he/she felt bad when the staff spoke to him/her in this manner and felt like he/she is supposed to apologize to the staff. [s. 3. (1) 1.] (109)

2. The licensee has failed to ensure that every resident has the right not to be neglected by the licensee or staff.
On an identified date, the family member of resident 62 discovered the resident's brief to be saturated in urine.
Record review of the home's investigation notes and interview with the nursing consultant indicated that resident 62's brief was not changed for five hours. The home considered this an incidence of neglect. [s. 3. (1) 3.]
(211)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision
des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 23rd day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Joelle Taillefer

Service Area Office /
Bureau régional de services : Toronto Service Area Office